STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MU A. BUII B. WIN	LDING	ONSTRUCTION 01	(X3) DATE S COMPL 10/26/	ETED	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	•	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	State Licensure State the Indiana State		K00	000			
	Provider Numbe AIM Number: 1						
	Surveyor: Mark Code Specialist	Caraher, Life Safety					
	Terrace Nursing found not in com Requirements fo Medicare/Medic 483.70(a), Life S 2000 Edition of Protection Associately Code (LS	r Participation in aid, 42 CFR Subpart Safety from Fire and the					
	basement was de III (211) constru sprinklered. The system with smo	etermined to be of Type ction and fully efacility has a fire alarm ake detection on all levels and in all areas open to					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/26/2012
HARCOL	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 91 at the time of this visit.			
	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.			
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/31/12.			
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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Event ID: Y7WM21

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155149		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE (COMPL 10/26/	ETED	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 HA	DDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0029 SS=E	hour fire-rated do automatic fire ext accordance with a protects hazardor approved automatic system option is useparated from or resisting partitions self-closing and reprotective plates inches from the big permitted. 19.3 1. Based on obstitute facility failed doors to the Mair provided with a provide	ed construction (with \(^3\)4 ors) or an approved inguishing system in 8.4.1 and/or 19.3.5.4 us areas. When the stic fire extinguishing used, the areas are ther spaces by smoke s and doors. Doors are non-rated or field-applied that do not exceed 48 ottom of the door are 8.2.1 ervation and interview, If to ensure 1 of 1 kitchen in Dining Room was positive latching device into the door frame. actice could affect 45 ind visitors in the vicinity ing Room.	K002	29	The creation and submission of this Plan of Correction does not constitue an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567L, Plan of Correction, be considered the Letter of Credit Allegation of Compliance and respectfully requests a desk review of the enclosed information. K0029 It is the practice of this provider to ensithat all hazardous areas are protected by a one hour fire raconstruction or an approved automatic fire extinguishing system in accordance with 8.4 and/or 19.3.5.4. 1. What corrective action will be accomplished for those resider found to have been affected by the deficient practice? No residents were affected. 2. How will you identify other residents	ot of of ole ure ted .1 onts y	11/20/2012

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Event ID: Y7WM21

Facility ID: 000070

If continuation sheet Page 3 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155149	B. WIN			10/26/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	to latch the door	into the frame.			having the potential to be affect by these deficient practices an		
					what corrective action will be	iu	
	3.1-19(b)				taken?All residents that eat in	the	
					main dining area have the		
	2. Based on obs	ervation and interview,			potential to be affected. A nev	v	
		d to ensure 1 of 1 kitchen			maintenance director will be		
		ms was separated from			educated by corporate		
	_	Room with smoke			maintenance personnel on this		
	_	This deficient practice			code when hired. All staff will inserviced on the new door	D C	
	_				system by 11-20-12.3. What		
		residents, staff and visitors			measures will be put into place	e or	
	in the vicinity of	the Main Dining Room.			what systemic changes will yo		
					make to ensure that the deficie	ent	
	Findings include	e:			practice does not recur?A 48		
					inch, 1 hour fire rated door will	be	
	Based on observ	ations with the			installed to seperate the main dining room from the		
	Maintenance Su	pervisor during a tour of			kitchen/dishroom by 11-15-12.		
		10:55 a.m. to 1:35 p.m.			The doors will be attached to t		
	1	kitchen dishwashing			facility fire alarm system with		
	· ·	to the kitchen. In			magnetic holds so that when the		
	_	chen dishwashing room is			fire alarm sounds the doors wi		
		_			release providing protection to		
	_	n Dining Room because			hazardous area. The doors will also have a panic bar installed		
		e Main Dining Room are			and be self closing into a posit		
	1 ^	a service window which			latching frame.A new	-	
	_	Main Dining Room.			maintenance director will be		
		ew at the time of the			educated by corporate		
	observations, the	e Maintenance Supervisor			maintenace personnel on this	la a	
	acknowledged th	ne kitchen dishwashing			code when hired. All staff will inserviced on the new door	υe	
	room was open t	to the kitchen and the			system by 11-20-12. 4. How	will	
	•	hing room is also open to			the corrective action(s) be		
	the Main Dining				monitored to ensure the deficie	ent	
		, 2200111.			practice will not recur, ie, what		
	3.1-19(b)				quality assurance program will	be	
	J.1-19(U)				put into place?A cqi tool to	_	
					monitor hazardous areas will be completed weekly x4, monthly		
					Completed weekly X4, Indittilly	^_	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUILDING	01	COMPLETED 10/26/2012
		100148	B. WING		10/20/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		ARCOURT RD IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	and quarterly thereafter, for at	
				least 6 months. Action plans to be adjusted until 95% compliar is achieved.5. Date of compliance 11-20-12	vill

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Event ID: Y7WM21

Facility ID: 000070

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149			LDING	O1	(X3) DATE : COMPL 10/26/	ETED	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	•	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0048 SS=E	all patients and for event of an emerging Based on record facility failed to fire extinguishers plan for the facility emergency. LSC written health carplan that shall precedent (1) Use of alarms (2) Transmission department (3) Response to a (4) Isolation of five five five five five five five fiv	plan for the protection of or their evacuation in the gency. 19.7.1.1 review and interview, the include the use of kitchen is in the written fire safety ity in the event of an C 19.2.2.2 requires a re occupancy fire safety ovide for the following: In of alarm to the fire alarms ire immediate area of smoke compartment of floors and building for ent of fire actice could affect 45 and visitors in the vicinity ing Room.	K00)48	K0048 It is the practice of this provider to ensure there is a written plan for the protection of all patients and for their evacuation in the event of an emergency.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected.2. How will you idention other residents having the potential to be affected by the deficient practices and what corrective action will be taken? residents that reside at the fact have the potential to be affected. A new maintenance director who be educated on this code by corporate maintenance personnel when hired. All staff be inserviced on the disaster pedit to include the use of kitchefire extinguishers 11-20-12.3. What measures will be put into place or what systemic change will you make to ensure that the deficient practice does not recompliance that the deficient practice does not recompliance to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on the code by corporate maintenance director will be educated on the code by corporate maintenance director will be educated on the code by corporate maintenance director will be educated on the code by corporate maintenance director will be educated on the code by corporate maintenance director will be inserviced on the edit to the disaster plan to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on the code by corporate maintenance director will be inserviced on the edit to the disaster plan to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on the edit to the disaster plan to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on the edit to the disaster plan to include the use of kitchen fire extinguishers on 11-10-12A new maintenance director will be educated on the edit to the disaster plan to include the use of kitchen fire extinguishers on 11-10	fy se PAII illity ed. ill viill vies ee ie ur?	11/20/2012

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Facility ID: 000070

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	of Correction identification number: 155149	(X2) MULTIPLE CO A. BUILDING	01	COMPLETED 10/26/2012
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plans for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. 3.1-19(b)		use of kitchen fire extinguishers 11-20-12. 4. He will the corrective action(s) be monitored to ensure teh defici practice will not recur, ie, what quality assurance program wil put into place? A cqi tool will be completed monthly to review t disaster plan x3, and quarterly thereafter, for at least 6 month Action plans will be adjusted u 95% compliance is achieved. S Date of compliance 11-20-12	ent t I be e he v is.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MI A. BUII B. WIN	LDING	O1	(X3) DATE S COMPL 10/26/	ETED	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0064 SS=E	health care occup 9.7.4.1. 19.3.5. 1. Based on obsethe facility failed portable fire exti- year hydrostatic subjected to the a procedures every NFPA 10, Standa Extinguishers Chextinguishers pas 6-year requirement maintenance info suitable metallic material having a inches by 3 1/2 in shall be affixed to process, and any shall be removed the self destruction from a fire exting label shall include information: (a) Month and year performed, indice such as is done book (b) Name or inition the maintenance performing the in NFPA 10 at Sector	guishers are provided in all pancies in accordance with 6, NFPA 10 ervation and interview, 1 to ensure 3 of 13 inguishers requiring a 12 itest were emptied and applicable maintenance of six years as required by and for Portable Fire papter 4-4.3. Fire paster 4-4.3 is a saint have the permation recorded on a label or equally durable a minimum size of 2 inches. The new label to the shell by a heatless old maintenance labels 1. These labels shall be of the type when removal guisher is attempted. The late the following the type when perforation by a hand punch, als of person performing and name of agency	K00	064	K0064 It is the practice of this provider to ensure there are portable fire extinguishers in a health care occupancies in accordance with 9.7.4.1.1. Wi corrective action will be accomplished for those reside found to have been affected by the deficient practice? No residents were affected.2. Ho will you identify other residents having the potential to be affect by these deficient practices are what corrective action will be taken? All residents that reside the facility have the potential to affected. A new maintenance director will be educated on the monitoring of fire extinguisher collars by corporate maintenance personnel when hired. The housekeeping and laundry supervisor will be inserviced a back up designee3. What measures will be put into place what systemic changes will you make to ensure that the deficient practice does not recur? The facility outside vendor corrected the 3 portable fire extinguisher on 10-30-12. A new maintenance director will be educated on the code when hired by corporate maintenance personnel. The housekeeping and laundry supervisor will be inserviced a back up designee4. How will the back up designee4. How will the back up designee4.	hat nts y w s cted ad at be e nce s a e or u ent ed rs cce is	11/20/2012

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION OA	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155149	A. BUI	LDING	01	10/26/	
		130148	B. WIN			10/20/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	IDT TEDDACE NI II	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
					Al OLIS, IIV 40200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		tenance that includes	+	IAG	corrective action(s) be monitor		DATE
	internal examina				to ensure teh deficient practice		
					will not recur, ie, what quality		
	~	have a "Verification of ocated around the neck of			assurance program will be put		
					into place?A cqi tool that will monitor the fire extinguisher		
		he collar shall contain a			collars will be completed mont	hlv	
		ece of uninterrupted			x3, and quarterly thereafter, fo		
	·	g a hole of a size that will			least 6 months. Action plans v		
		ollar assembly to move			be adjusted until 95% complia is achieved.5. Date of	nce	
		the container unless the			compliance 11-20-12		
	_	ely removed. The collar			56mpilarios 11 20 12		
		e with the operation of					
	_	sher. The "Verification of					
		hall include the month					
	_	vice was performed,					
		erforation such as is done					
	1 -	. This deficient practice					
		esidents, staff and					
	visitors.						
	Findings include	:					
	Based on observ	ations with the					
		pervisor during a tour of					
	the facility from	10:55 a.m. to 1:35 p.m.					
	on 10/26/12, the	following was noted for					
	three portable fir	e extinguishers in the					
	facility:						
	a. the portable fi	re extinguisher by the					
	Cedar Bay nurse	s' station had a label					
	affixed stating th	e six year maintenance					
	_	performed in March					
	_	o verification of service					
		ound the neck of the					
	container.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155149	B. WIN	G		10/26/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
1145001	IDT TEDDA OF AUU	DOING AND DELIABILITATION			ARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	DATE
	_	re extinguisher located in				
	1	the Maintenance Office				
		ed in 1989 and had a label				
	I -	ne most recent six year				
	_	cedures were performed				
	_	t it had no verification of				
		cated around the neck of				
	the container.					
		re extinguisher located in				
		rridor was manufactured				
	in 2005 and had	a label affixed stating the				
	_	ance procedures were				
	performed in Ap	ril 2011 but it had no				
	verification of se	ervice collar located				
	around the neck	of the container. Based				
	on interview at the	he time of the				
	observations, the	e Maintenance Supervisor				
	acknowledged ea	ach of the three portable				
	fire extinguisher	s in the facility was not				
	provided with a	verification of service				
	collar in the afor	ementioned locations.				
	3.1-19(b)					
	2. Based on obs	ervation and interview,				
		l to maintain 1 of 1				
	portable K-class	fire extinguishers in the				
	_	area in accordance with				
	the requirements	of NFPA 10, Standard				
	_	Extinguishers, 1998				
		10, 2-3.2 requires fire				
		ovided for the protection				
		ances using combustible				
	•	vegetable or animal oils				

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	OF CORRECTION IDENTIFICATION NUMBER: 155149	A. BUILDING B. WING	COMPLETED 10/26/2012
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP 8181 HARCOURT RD INDIANAPOLIS, IN 46260	CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)	SHOULD BE COMPLETION
	and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect staff or visitors in the vicinity of the kitchen. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, a placard was not conspicuously placed near the K-class portable fire extinguisher which states the fire protection system shall be activated prior to using the K-class portable fire extinguisher. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a placard was not conspicuously placed near the K-class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher.		

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Event ID: Y7WM21

Facility ID: 000070

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/26/2012
	ROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			

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Event ID: Y7WM21

Facility ID: 000070

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STATEMENT OF DEFICIENCIES		ľ ′		` '			B) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		01	COMPL		
		155149	B. WIN			10/26/	2012	
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE	
K0076 SS=E	NFPA 101 LIFE SAFETY CO Medical gas stora areas are protector NFPA 99, Standar Facilities. (a) Oxygen stora 3,000 cu.ft. are elseparation. (b) Locations for stan 3,000 cu.ft. a NFPA 99 4.3.1.1. Based on observer facility failed to storage locations cubic feet was error of 1 hour fire resideficient practice and any staff or standard	DDE STANDARD age and administration ed in accordance with ards for Health Care ge locations of greater than inclosed by a one-hour supply systems of greater are vented to the outside. 2, 19.3.2.4 ation and interview, the ensure 1 of 2 oxygen of greater than 3000 inclosed with a separation distive construction. This e could affect 30 residents visitor in the vicinity of ge and transfilling room Bend nurses' station.	K00		code when hired by corporate maintenance personnel. All st will be inserviced on appropria oxygen storage on 11-20-12.3 What measures will be put into place or what systemic change will you make to ensure that the deficient practice does not reco	ed 	11/20/2012	
	the facility from on 10/26/12, the the oxygen stora near the Willow a. the entry door rating label attac liquid oxygen tar room.	10:55 a.m. to 1:35 p.m. following was noted for ge and transfilling room Bend nurses' station: had no fire resistance hed to the door. Seven			director will be educated on this			

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	OF CORRECTION IDENTIFICATION NUMBER: 155149	A. BUILDING B. WING	COMPLETED 10/26/2012				
HARCO	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI TAG DEFICIENCY)	E COMPLETION DATE				
	long was observed in the wall near the floor by the entry room door which was not firestopped. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the entry door for the oxygen storage and transfilling room near the Willow Bend nurses' station was not one hour fire rated and the "L" shaped cut in the wall did not provide one hour fire resistive construction. 3.1-19(b)	room on 11-8-12. A new 1 if fire rated door was installed the oxygen storage room on 11-8-12. A new maintenance director will be educated on code when hired by corpora maintenance personnel. All will be inserviced on approp oxygen storage on 11-20-12 How will the corrective actio be monitored to ensure teh deficient practice will not rec what quality assurance prog will be put into place? A cqi t that will monitor the integrity oxygen storage will be completed weekly x 4, mont x2, and quarterly thereafter, least 6 months. Staff monitor will report non-compliance immediately to the Executive Director/Designee. Action p will be adjusted until 95% compliance is achieved.5. It of compliance 11-20-12	for this te staff riate d.4. n(s) cur, ie, ram cool of hly for at cring ellans				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. BUILDING 01		01	COMPLETED		
155149		B. WING				10/26/2012		
NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 30 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room near the Willow Bend nurses' station. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 10:55 a.m. to 1:35 p.m. on 10/26/12, the following was noted for		K0143		K0143 It is the practice of this provider to ensure that the transferring of oxygen is seperated from any portion of a facility wherein patients are housed, examined or treated by a separation or a fire barrier of 1 hour fire resistive construction.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No residents were affected.2. How will you identify other residents having the potential to be affected by these deficient practices and what corrective action will be taken?All residents that reside at the facility have the potential to be affected. A new maintenance director will be educated on this code when hired by corporate maintenance personnel. All staff		11/20/2012	

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STATEMENT OF DEFICIENCIES				, and the second			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUII	LDING	01	COMPLI		
		155149	B. WIN			10/26/	2012	
NAME OF P	PROVIDER OR SUPPLIER	£			ADDRESS, CITY, STATE, ZIP CODE			
LIADOOLIDT TERRACE NUIDOING AND DELIABILITATION			8181 HARCOURT RD INDIANAPOLIS, IN 46260					
HARCOURT TERRACE NURSING AND REHABILITATION					APOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
IAG	· · · · · · · · · · · · · · · · · · ·			IAG	will be inserviced on appropria	te	DATE	
	the oxygen storage and transfilling room near the Willow Bend nurses' station:				oxygen storage on 11-20-12.3			
					What measures will be put into		l l	
	a. the entry door had no fire resistance rating label attached to the door. Seven				place or what systemic changes			
	_	nks were observed in the			will you make to ensure that the deficient practice does not recur? The facility repaired the hole in the wall of the oxygen storage room on 11-8-12. A new 1 hour fire rated door was installed for the oxygen storage room on			
	room.	iiks weit ouserveu iii uit						
		cut measuring 24 inches						
	•	ed in the wall near the						
	_	y room door which was						
		y 100111 door willell was			11-8-12.A new maintenance			
	not firestopped. Based on interview at the time of the				director will be educated on thi	s		
					code when hired by corporate	off		
	observations, the Maintenance Supervisor acknowledged the entry door for the				maintenance personnel. All st will be inserviced on appropria			
	_	•			oxygen storage on 11-20-12.4			
	oxygen storage and transfilling room near the Willow Bend nurses' station was not one hour fire rated and the "L" shaped cut in the wall did not provide one hour fire resistive construction.				How will the corrective action(s			
					be monitored to ensure teh			
					deficient practice will not recur, ie,			
				what quality assurance program will be put into place?A cqi tool				
					that will monitor the integrity of			
	2.1.10/b)	2 1 10/b)			oxygen storage will be			
	3.1-19(b)				completed weekly x 4, monthly			
					x2, and quarterly thereafter, fo least 6 months. Staff will repor			
					any compromise of integrity in	`		
					the oxygen storage room to the			
					Executive Director immediately			
					Action plans will be adjusted to 95% compliance is achieved.5			
					Date of compliance 11-20-12	•		

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